APPLICATION FOR CERTIFICATION AS AN ACUPUNCTURE DETOX SPECIALIST

State Form 50711 (1-02)
Approved by State Board of Accounts, 2002

Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, Indiana 46204
Telephone number: (317) 234-2060
Email: hbp3@hpb.state.in.us

* Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8.1. Disclosure is mandatory, and this record cannot be processed without it.

APPLICATION FEE	
DATE FEE PAID	
RECEIPT NUMBER	
LICENSE NUMBER	
DATE LICENSE ISSUED	

APPLICANT
Attach two (2) passport type quality photographs of yourself taken within the last eight weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Address (*number and street or Rural Route*)	
City, state, ZIP code	
Telephone number (*daytime*)	Email address
Birthdate (*month, day, year*)	Birthplace

HIGH SCHOOL DIPLOMA / GED GRANTED BY

Name of school	
Location	Date of graduation (*month, year*)

ACUPUNCTURE TRAINING FOR DETOXIFICATION

NAME OF PROGRAM	LOCATION	NUMBER OF HOURS	DATE CERTIFIED

OTHER EDUCATION AND TRAINING IN THE UNITED STATES

NAME OF SCHOOL	LOCATION	FROM (*month, year*)	TO (*month, year*)

LIST ALL PLACES YOU HAVE LIVED SINCE YOUR MOST RECENT DEGREE

GENERAL LOCATION	DATE

LIST ALL PLACES YOU HAVE WORKED SINCE YOUR MOST RECENT DEGREE		
NAME AND ADDRESS OF EMPLOYER	**RESPONSIBILITIES**	**DATE**

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	**TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT**	**NUMBER**	**DATE ISSUED**	**CURRENT STATUS**

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If it is a malpractice settlement or judgement against you, please provide name(s) of plaintiff(s) and settlement amount. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following, is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held in any state?	☐ Yes ☐ No
2. Has you ever been denied a license, certificate, registration or permit to practice any regulated health occupation in any state (*including Indiana*) or country?	☐ Yes ☐ No
3. Are you now being, or have you ever been treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
4. Have you ever been diagnosed with drug addiction?	☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or nolo contendere to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor traffic laws resulting in fines.*)	☐ Yes ☐ No ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of their authorized representatives in connection with processing my application for acupuncture detoxification specialist.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau, and the Medical Licensing Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Date signed (*month, day, year*)	Signature of applicant

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE SUPERVISOR

SUPERVISING PHYSICIAN / ACUPUNCTURIST / PROFESSIONAL ACUPUNCTURIST

Name of supervisor (*last, first, middle, maiden*)	Social Security number *
License number	Date license expires (*month, year*)
Residence address (*number and street, city, state, and ZIP code*)	
Office address *(number and street, city, state, and ZIP code*)	
Residence telephone number	Office telephone number
Date of birth	Place of birth
Email address	

MEDICAL, PROFESSIONAL / ACUPUNCTURE DEGREE

Name of school	Location	Date of graduation

INSTRUCTIONS: Give a description of your practice, areas of specialization, and / or board certification

JOB DESCRIPTION FOR THE ADS

INSTRUCTIONS: ON AN ATTACHED SHEET, give a description of the exact privileges and tasks the ADS shall be performing under your supervision. In addition, please give a detailed description of the process maintained for evaluation of the ADS.

LIMIT ON ADS SUPERVISION

As a supervising physician or professional acupuncturist or acupuncturist, I understand that I may NOT supervise any more than twenty (20) Acupuncture Detox Specialists at a time. Please list the names and certificate numbers of the ADS you are currently supervising.

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the Acupuncture Detox Specialists (ADS) named in this application will be under your continuous supervision in accordance with IC 25-2.5 and 844 IAC 13, and that you shall review all records of patient encounters performed by the ADS at least one time per month after the encounter and at all times retain professional and legal responsibility for the care rendered by the ADS.

Signature of supervisor	Date signed (*month, day, year*)

AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Date signed (*month, day, year*)	Signature of supervisor

AUTHORIZATION FOR RELEASE OF INFORMATION

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I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and hereby specifically release the Bureau, and the Medical Licensing Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Date signed (*month, day, year*)	Signature of supervisor